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MENTAL HEALTH AND THE ELDERLY

REPORT FOR THE

ALBERTA MENTAL HEALTH STUDY

By

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[redacted]

October 10, 1968

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"CAST ME NOT OFF IN THE TIME OF OLD AGE;

FORSAKE ME NOT WHEN MY STRENGTH FAILETH."

Psalms, 71

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I INTRODUCTION

The Director of the Alberta Mental Health Study invited me in late August, 1968 to carry out a survey and submit a research paper on aspects of aging relevant to the Study. Unfortunately, the present submission cannot be considered an adequate answer to this request. The complex problems, the collation and evaluation of statistics, the gleaning of advice from many consecrated and experienced public servants in Alberta, all demand much more time than has been available. It has not proved possible to do more than scratch at the surface of different viewpoints, interests and conflicts. The most valuable outcome of this report could be its function as a stimulus for a more thorough investigation with a more adequate statistical basis for recommendations.

Having seen something of the work of those who labor on behalf of the elderly, especially the elderly sick, in Alberta, it seems almost presumptuous to comment on their devotion to those in their care. Often in extremely trying circumstances without the benefit of facilities which a younger generation takes for granted, much has been accomplished. Suggestions for future improvements imply an appreciation of the baseline from which improvements can commence, due to the efforts of past and present staff.

II LIMITATIONS OF EXISTING STATISTICAL DATA

The Dominion Bureau of Statistics and various departments of the Provincial Government request, obtain and publish statistical summaries of information from institutions in the Province. However, the lack of consistency in the categorization of data often makes it difficult to draw well-founded conclusions. Sometimes provincial breakdowns are not presented, and sometimes the Alberta figures are part of a Prairie Provinces conglomeration. Age distributions are usually given by decades, but occasionally an age group such as that from 25 to 44 is compared to the over 60's. Further, much of the data is based on 1961 census figures, and the increase in population since then makes the earlier information somewhat suspect. The difficulty in discovering facts can be illustrated by the absence of published information about the length of confinement

of residents in Alberta Mental Hospitals. The gaps in tables and graphs presented in the present document are not, therefore, due to careful selection in order to strengthen arguments, but are the result of utilizing information which happens to be readily available.

A word of caution in the interpretation of statistical information, and the prevailing tendency to equate numerical figures with science, would not be out of place. Ex post facto deductions can always be explained on the basis of more than one hypothesis, and the obvious or first conclusion may be unwarranted. For example, over the last few years the number of patients released from mental hospitals has increased, and it might be thought that this was solely due to improved therapy and changed outlooks among psychiatrists. However, a Calgary physician informed me that he had had the experience of patients returning from Alberta mental hospitals before they were, in his opinion, ready to do so. As a result, he attempts to obtain beds for his elderly mentally disturbed patients in auxiliary hospitals to obviate this difficulty. This implied support for Disraeli's dictum that there are three kinds of lies - lies, damn lies and statistics - does not mean that statistics are valueless. They are invaluable as a first step, and it is important that those who toil to provide them realize that they will be used with caution, but used.

The question of what statistics are needed, and which are perhaps superfluous, requires careful attention. This is an area where centralization may be preferred, since coordination can prevent duplication. It is therefore suggested that a senior member of the Mental Health staff of the Department of Public Health consult with the Hospitals Division of the Ministry, the Provincial Statistician, the Ministry of Welfare, the Dominion Bureau of Statistics, the Superintendent and Matrons of the hospitals, as well as interested research workers, on the question of data collection and publication (see also (7))*.

III SERVICES FOR THE ELDERLY AND THEIR COST

For present purposes aging can be characterized as associated with an increase in probability of requiring individual help from others in order to survive and to adjust to the environment. Of course, it is not only the elderly who need such help, and many older people are as

*Numbers in parentheses refer to publications listed on p. 28.

independent as the young. However, the likelihood of the presence of such needs becomes greater with age. The reason why the need for help increases is primarily because of biological and psychological age-related changes, but it is also due to a loss of socially approved roles and economic hardships. The extent and nature of these needs ought to be compared with the extent and nature of services offered in Alberta, so that an overview of the general mental health of the elderly can be obtained. For it is clear that nothing is more frustrating, and therefore injurious to mental health, than unfilled basic needs. Any exact comparison between needs and services, however, must be considered an impossible task at present. In place of this, the emphasis will be on attempting to assess how far facilities appear to be fulfilling their declared aims.

Modern industrialized societies meet the requirements of the aged in a variety of ways. The unbiased observer must surely conclude that on the average, public facilities offered to the elderly sick are vastly superior to those available in the past. The accepted aim is to provide a network of services and institutions with different functions. Some of the more important of such services offered in Alberta, with their reported costs are enumerated in Table 1. Alberta's emphasis has been on gradated services, with attempted differentiations between chronic and acute illnesses, between mental and physical illness, and between cases which require constant attention from registered nurses and those where the registered nurse occupies a supervisory role or where occasional home visits suffice. In most cases, the "user" pays a minimal amount and the brunt of the cost is born by public funds.

With one exception, the services provided by the various institutions listed in Table 1 are not confined to the aged, although the elderly constitute a much larger proportion of "users" than the proportion of the elderly in the population as a whole. This is exemplified in Table 2, where age distributions from census figures and those of "Service Users" are listed. It will be seen that the vast majority of recipients are over 60 years old. This table supports the earlier argument that with age special needs tend to increase.

There are some facilities financed from public funds where beneficiaries belong preponderantly to younger age groups - an obvious instance being education. Some other examples more relevant to mental

TABLE 1

EXAMPLES OF ALBERTA FACILITIES AND ESTIMATED COST PER DAY

Facility	"User"	COST TO: Public Funds	Patient
Mental Hospitals (3), (15)	Acute & Chronic	$4.97 - 9.46	$2.00
General Hospitals (4)	Acute	$32.99 - 101.19 (over 200 beds)	$2.50
Psychiatric Wards of General Hospitals	Acute	$32.99 - 101.19 (over 200 beds)	$2.50
Auxiliary Hospitals (4)	Chronic	$11.30 - 44.63	$2.00
Nursing Homes (6)	Chronic	$7.50	$3.00
Senior Citizen Homes: Lodges (15)	"Well Aged"	($0.03 in Calgary, 1967)	$2.50 ($70.00-77.50 /month)
Victorian Order of Nurses (15)	Acute	$3.82 (per visit in Calgary)	According to means

TABLE 2

EXAMPLES OF FACILITY USERS OR BED CAPACITY:

PERCENTAGE AGE DISTRIBUTION

FACILITY	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+	Total Number Users
Mental Hospitals (15) Ponoka, 1968	--	3.92	8.50	9.06	17.18	19.77	21.10	12.32	5.05	0.93	1,071
(15) Claresholm, 1968	--	--	--	2.16	8.40	27.82	35.25	18.23	7.67	0.48	417
General Hospitals (Including Psychiatric Wards), 1967 (15)	14.2	8.7	6.6 (Ages 20-24)	10.5 (Ages 25-34)	10.7 (Ages 35-44)	11.6 (Ages 45-54)	11.7 (Ages 55-64)	6.1 (Ages 65-69)	19.9 (Age 70+)		2,847,567 (Patient Days)
Auxiliary Hospitals, 1966 (4)	0.3	0.7	0.9	2.9	3.7	7.1	13.7	27.8	35.7	7.2	2,082
Nursing Homes, 1967 (6)	0.1	--	0.3	0.6	1.5	3.4	9.8	28.4	45.4	10.0	3,886
Senior Citizen Lodges (Calgary) 1968 (15)							27.73 (Ages 65-75)	56.74 (Ages 76-85)		15.53 (Age 85+)	779
Victorian Order of Nurses, 1968 (15)	4.01	1.34	2.34	2.67	6.34	5.67	13.67	29.34	31.01	3.67	300
General Population Alberta Census 1966 (10)	24.0	19.5	13.5	12.9	11.3	8.3	5.5	3.3	1.1	0.11	1,463,203

health are listed in Table 3. The decrease with age of incidence of mental deficiency is the result of shorter life expectancy, while the reduction in crime rates might be interpreted as due to an increase in wisdom. Guidance Clinic statistics are probably the outcome of a tradition that such facilities service the young.

It will be noted in Table 1 that charges to public funds vary greatly. At least part of the reason for this is that the costs quoted are not always comparable. Interest payments, capital depreciation, profit (for owners of private nursing homes), medical and drug expenses are included in some cases and omitted in others. Even within a specific grouping of institutions costs show gross fluctuations, as is demonstrated in Table 4 which gives a breakdown of some general hospital figures. The cost per patient day in a psychiatric ward of a general hospital is almost certainly less than the figures show, since a surgical patient will contribute disproportionately to an overall average hospital figure. Further, psychiatrists and others employed in the University of Alberta Hospital, Edmonton, and Foothills Hospital, Calgary, make very important medical contributions outside their specific duties in the hospitals, but the price of these is hidden in the bed costs.

Notwithstanding reservations about the reliability of the quoted figures, it is clear that it is impossible to divorce decisions concerning the best type of institution for answering the needs of the elderly from the costs involved. This must not be taken to imply that the cheapest is best; economic aspects cannot be the only consideration, nor yet the most important consideration, in our affluent society. In fact, a case could be made for increasing expenditures on those facilities which are operated very cheaply. It would nevertheless be unrealistic to recommend solutions to problems which necessitate, say, a sudden tenfold increase in Provincial Government expenditures on the mentally ill. The data presented in the tables also show that decisions concerning the distribution of government funds between different facilities are likely to have profound effects on the services offered to individuals. The location of a citizen's residence may perhaps determine whether he receives the equivalent of, say, $5,000 worth of care or $1,000 worth. It is also worth emphasizing that the costs of homes for the elderly and the provision of nursing services for older people in their own homes

TABLE 3

EXAMPLES OF SYMPTOMS DECREASING WITH AGE:

PERCENTAGE AGE DISTRIBUTION

	Below 20	20-29	30-39	40-49	50-59	60-69	70+	Total Numbers
Mental Deficients (Deerhome & Alberta School Hospital) (2) & (15)	39.26	20.79	11.99	12.17	9.15	5.30	1.36	2285
Alberta Criminal Offences (9)	29.82 (Below 20)	21.99 (Ages 20-24)	21.62 (Ages 25-34)	11.24 (Ages 35-44)	6.31 (Ages 45-54)	3.74 (Age 55+)		4508
Alberta Guidance Clinics (2)	86.8 (Below 20)	4.4	6.7 (Ages 31-50)		2.1 (Age 50+)			3975

TABLE 4

BREAKDOWN OF COSTS FOR SELECTED

GENERAL HOSPITALS (4)

HOSPITAL	Gross Salaries and Wages		Medical and Surgical Supplies		Drugs		Administration		Food		Laundry and Linen		Plant Operation, Maintenance & Housekeeping		Interest		Depreciation		All Other		Total	
	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Meal Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day
200 - 499 BEDS																						
Calgary, Holy Cross	$ 2,840994	$ 26.27	$ 135024	$ 1.24	$ 150244	$ 1.38	$ 168862	$ 1.56	$ 191571	$ .92	$ 42448	$ .39	$ 128710	$ 1.19	$ 204666	$ 1.89	$ 896582	$ 8.26	$ 191356	$ 1.76	$ 4,950457	$ 45.61
Calgary, Foothills	1,393888	49.46	88844	3.15	30942	1.10	134498	4.77	107947	1.89	11811	.42	161229	5.72	822560	29.19	-	-	99616	3.54	2,851335	101.19
Edmonton, General	2,643648	23.14	142689	1.25	125833	1.10	146105	1.28	270250	1.22	42716	.37	228126	1.99	74853	.66	179065	1.57	173130	1.52	4,026415	35.25
Edmonton, Glenrose	1,766053	22.85	30166	.39	28266	.37	161333	2.09	261905	2.79	19073	.25	204608	2.65	184986	2.39	-	-	66356	.86	2,722746	35.24
Edmonton, Misericordia	2,247843	23.55	96164	1.01	150263	1.57	153031	1.60	169695	1.06	27235	.29	79445	.83	2229	.02	100512	1.05	129636	1.36	3,156053	33.06
Lethbridge, St. Michael's	1,217869	20.75	56636	.96	62458	1.06	65355	1.11	112041	1.07	12845	.22	152646	2.60	56032	.95	116818	1.99	84676	1.44	1,937376	32.99
Medicine Hat	1,411609	22.94	57760	.94	62531	1.02	80789	1.31	100081	.96	19195	.30	44971	.73	75099	1.22	147921	2.40	91562	1.49	2,090518	33.98
TOTAL	$13,521904	$ 24.86	$ 607283	$ 1.12	$ 610537	$ 1.13	$ 909973	$ 1.67	$1,213490	$1.28	$174323	$ .32	$ 999735	$ 1.84	$1,420425	$ 2.61	$ 1,440898	$2.65	$ 836332	$ 1.53	$21,734900	$ 39.96
500 BEDS AND OVER																						
Calgary, General	6,832884	23.02	319827	1.08	313596	1.06	396036	1.33	574124	1.10	57742	.19	246898	.83	291608	.98	325668	1.10	347969	1.17	9,706352	32.69
Edmonton, Royal Alexandra	6,229857	25.83	354468	1.47	352801	1.46	407570	1.69	573047	1.46	277344	1.15	410744	1.70	496964	2.06	276534	1.15	678688	2.81	10,058017	41.70
Edmonton, University	8,013203	26.38	505062	1.66	619913	2.04	449553	1.48	611248	1.17	91548	.30	342367	1.13	1,164179	3.83	247323	.81	774514	2.55	12,818910	42.19
TOTAL	$21,075944	$ 25.03	$1,179357	$ 1.40	$1,286310	$ 1.53	$1,253159	$ 1.49	$1,758419	1.23	$426031	$ .51	$1,000009	$1.19	$1,952751	$ 2.32	$ 849525	$1.01	$ 1,801171	$ 2.13	$32,583279	$ 38.70
GRAND TOTAL	$33,588688	$ 21.79	$2,515630	$ 1.63	$1,896470	$ 1.22	$3,482902	$ 1.42	$5,057804	$ 1.19	$926483	$ .37	$3,733297	$ 1.52	$4,290994	$ 1.74	$ 4,452051	$1.81	$ 3,963380	$ 1.61	$85,011681	$ 34.56

constitute a negligible expense in comparison with any kind of institution with organized medical fulltime services.

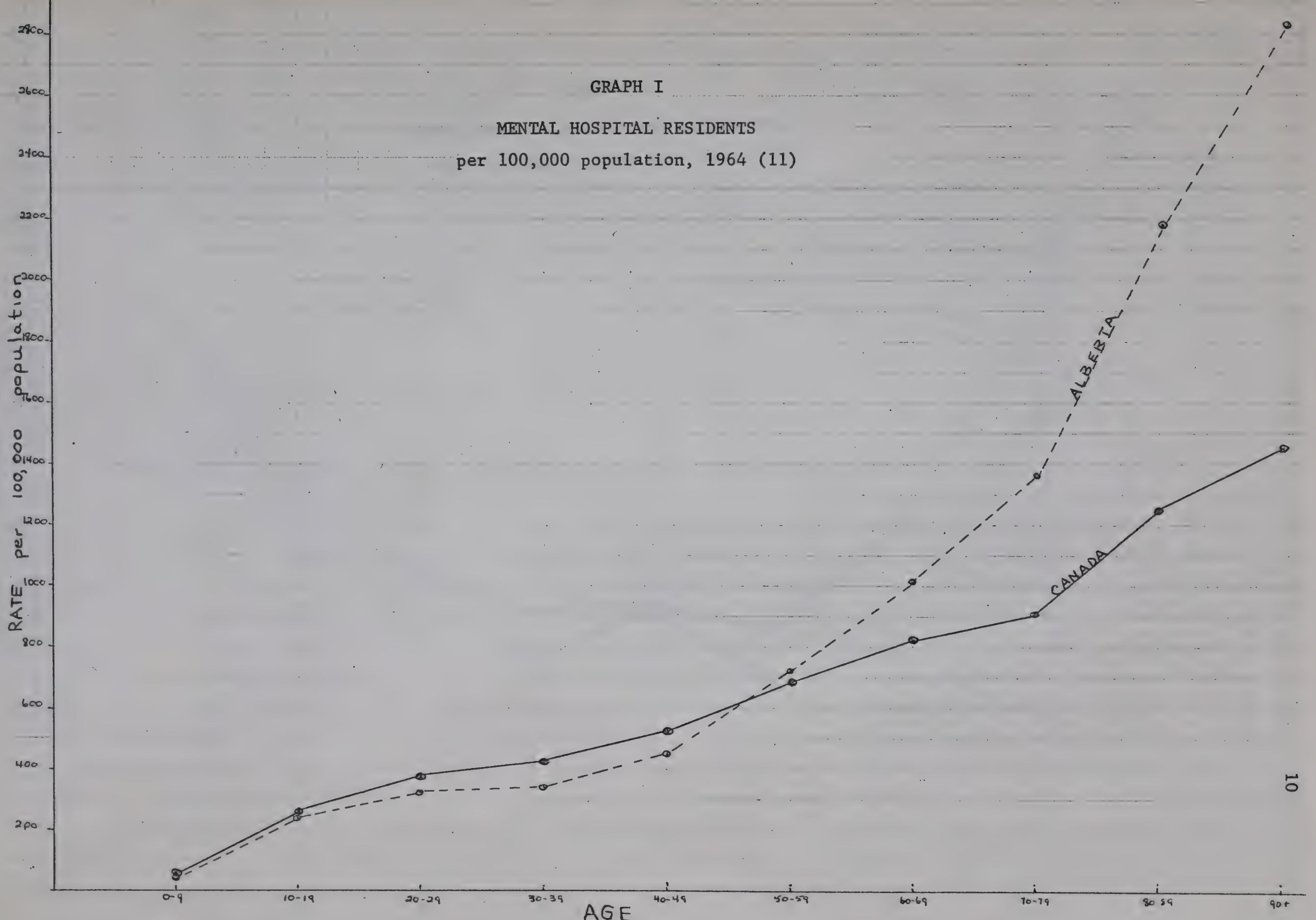
IV ALBERTA HOSPITALS, PONOKA AND EDMONTON

Because of the desire to provide gradated care in different institutions and also because of changed outlooks towards mental illness, the two large Alberta Mental Hospitals, each with approximately 1,000 beds, have come to be thought of as places for active treatment of acute disorders. In Alberta, as in the whole of Canada, admission and discharge rates have increased two to threefold since 1955, while length of stay in mental hospitals has decreased (7). Some elderly patients, however, may have improved sufficiently to be discharged from a mental hospital, but still require care and facilities unavailable elsewhere. Half-way houses, foster parents and sheltered workshops, which ease the transition from hospital to normal environments, are often unsuited for the elderly. For such patients, mental hospitals function more like an auxiliary hospital or nursing home. Graph 1 pictures the number of patients per 100,000 population in Alberta mental hospitals and those in Canada as a whole by age group. It is clear that till the age of 50, Alberta parallels the position elsewhere, but beyond that age there is a definite and increasing difference between the two curves. In other words, Alberta has proportionately more older people in mental hospitals than the rest of Canada. The basis for this difference is illustrated in graphs 2a and 2b. These graphs depict the proportion of admissions to and discharges from Alberta mental hospitals by age groups, as a percentage of the Canadian totals. Apart from the very young, discharge rates do not seem to vary significantly from Alberta's proportion of the general population (about 6% at the time). There is a drop in admission rates compared to Canada as a whole till the fifth decade, when more males begin to be admitted. The increase in female admissions begins in the 60's. In summary, more older people are admitted, while discharges remain constant. The reasons for the difference between Alberta and the average Canadian rate require further investigation, but one implication is obvious. Any recommendation to reduce the number of mental hospital beds must include consideration of the disposal of elderly patients.

GRAPH I

MENTAL HOSPITAL RESIDENTS

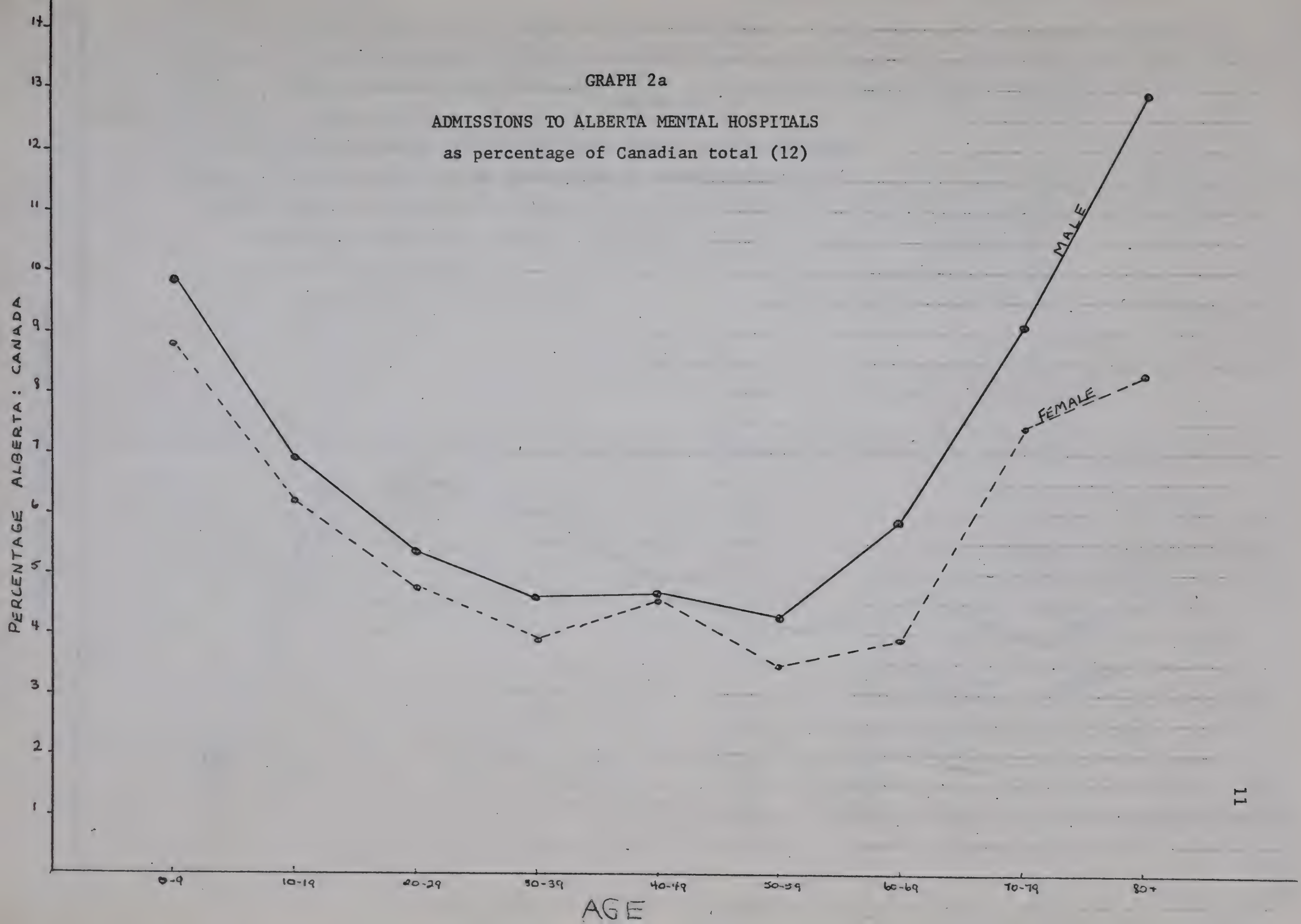
per 100,000 population, 1964 (11)



GRAPH 2a

ADMISSIONS TO ALBERTA MENTAL HOSPITALS

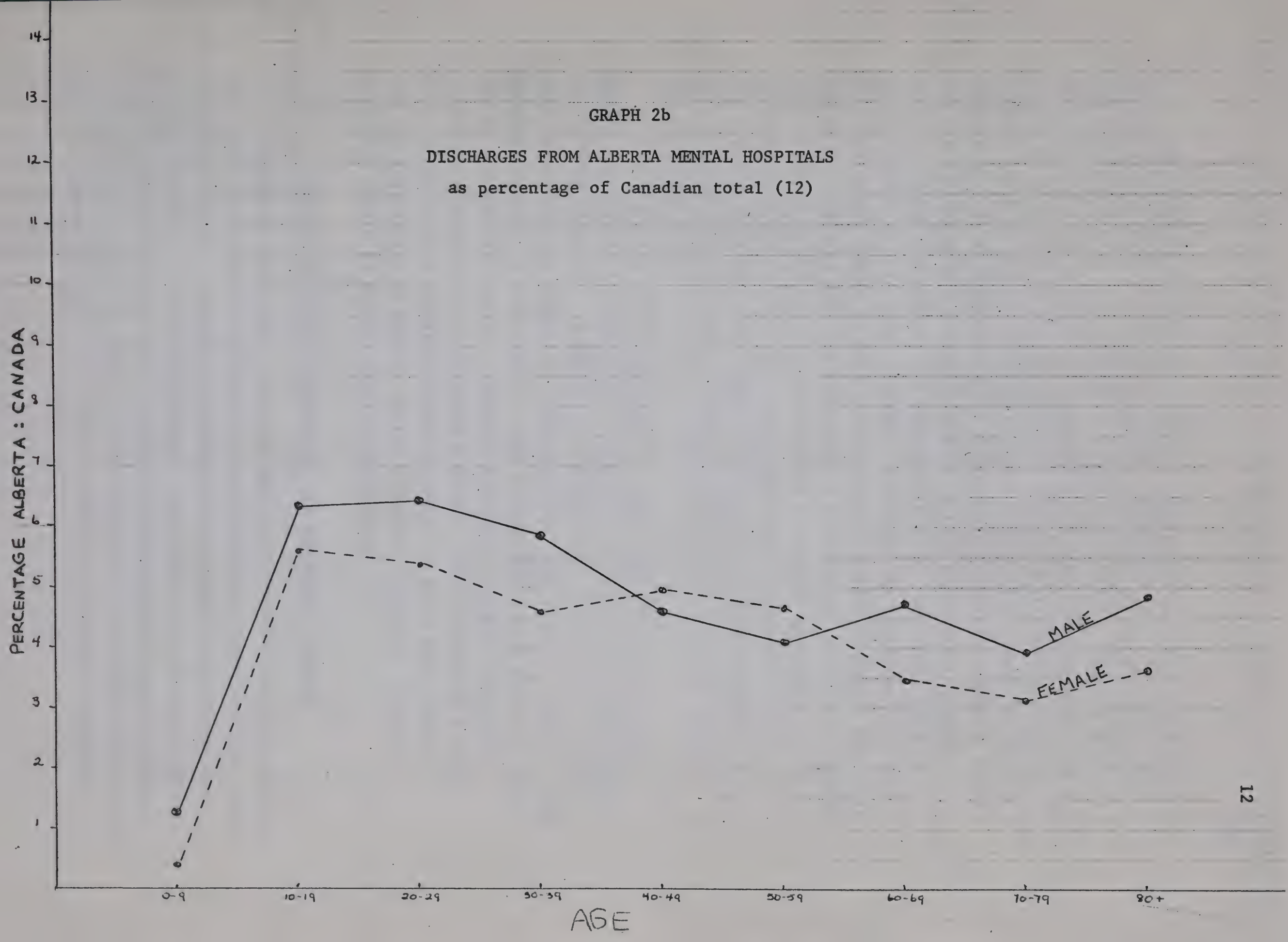
as percentage of Canadian total (12)



GRAPH 2b

DISCHARGES FROM ALBERTA MENTAL HOSPITALS

as percentage of Canadian total (12)



The suggestion that some elderly inmates do not need to be kept in mental hospitals raises the question of whether there are also some who should not have been committed in the first place. Perhaps gradated care for the elderly results in unnecessarily fine distinctions. The degree of confusion in elderly patients which requires exclusion from nursing homes or auxiliary hospital has not been, and cannot be, clearly demarcated. It will depend on the tolerance for aberrant behavior among the staff concerned, and this tolerance in turn depends on training, as well as resources available for psychiatric help. The point will be further elaborated in later sections, but again the implication is that decisions about number of beds for the elderly needed in mental hospitals cannot be separated from the provision of alternative facilities elsewhere. Even the type of elderly patient admitted to Alberta Hospitals will be affected by other facilities. One psychiatrist recently told me that his clinical impression was that the proportion of those seriously disturbed among recently admitted elderly patients had increased during the last year or so.

The location of the two hospitals and means of access through public and private transportation has particularly important implications for elderly patients. It has to be realized that the children of people aged 80 or over are themselves often elderly. For them, or even for those somewhat younger, a long drive or even a short drive on a difficult highway to the Alberta Hospital, Edmonton sometimes presents insuperable problems, preventing their visiting a parent. The building of a better road to the Alberta Hospital, Edmonton should be given some priority and the possibility of regular public transport facilities to both hospitals should be brought under consideration.

V ALBERTA HOSPITAL, CLARESHOLM, AND ROSEHAVEN, CAMROSE

These two hospitals, each with about 500 beds and a hundred patients per ward, are designated as chronic mental hospitals. With very few exceptions, patients are admitted only after they have spent some time at the Alberta Hospital in Ponoka or Edmonton. The director of the Mental Health Division of the Ministry acts as Medical Superintendent at both Claresholm and Rosehaven, while the matrons of the respective institutions are responsible for general supervision. However, there are important differences

between the two hospitals. For example, admissions to Rosehaven are confined to those over 70 years old, while Claresholm caters for all age groups, although in fact some 60% of the patients are aged 60 or over. The ommission of the label Alberta Hospital from the title of Rosehaven is also worthy of note. It might be thought that a Rosehaven by any other name would smell just as sweet, but the social stigma for families that mother or father resides in a mental hospital is avoided by the change in nomenclature.

There seems to be a sufficient supply of untrained helpers at these institutions, but it is astonishing that no psychiatrist, social worker or psychologist has been allocated to the hospitals, and it is even more distressing to report that the total complement of certified nurses is about 15 in each hospital. (Medical services are available from local doctors, who do not appear to have any special qualifications in psychiatry, neurology or geriatrics.) This means that there are only two, or perhaps three people with any level of accepted training looking after 500 patients at night-time. Incontinence is the accepted way of life at Rosehaven, and patients able to control themselves may have to wait up to two hours before someone comes on regular rounds to help them to the bathroom. Mentally normal younger individuals would have difficulty in coping with such situations. Although it is pointless to allocate blame for this state of affairs, it is important when criticism is implied to ensure that those carrying out their duties in exemplary fashion do not suffer censure. I want, therefore, to pay personal tribute to the matrons of Claresholm and Rosehaven for the care they provide for their patients, and their example in displaying sympathetic attitudes, which their staff follow.

Many of the patients in these hospitals have no contact with family or friends. It is difficult to obtain facts concerning the number who receive visitors, but an estimate of 15% is probably high. Because the hospitals are far from large centers of population, visits by families will usually involve considerable sacrifices. The visit itself is likely to be heart-rending, and people will understandably manufacture rationalizations in order to avoid such painful experiences. The number of years which have been spent in mental hospitals will also affect contacts with the outside world. Once again, figures are not readily available, but it seemed as if quite a few patients have been incarcerated for over twenty years.

It would be unfair and wrong to leave the impression that administrators in Edmonton had overlooked or forgotten the needs of the patients in these two hospitals. Any visitor, however emotionally upset, quickly realizes that improvements in buildings and equipment, costing many millions of dollars are taking place. But overworked administrators have not the time necessary to weigh priorities with the required care, especially when the only pressures felt are from those lower down in a civil service hierarchy. For example, some patients' beds are still only two-and-a-half feet in width and these are being slowly replaced by more standard sizes. This is, of course, essential considering the dimensions of older people's bodies. The replacement, it is said, cannot be undertaken rapidly because of the expense involved - an expense which almost certainly does not exceed $10,000. This seems a pitiful example of saving taxpayers' money, especially in view of the costs of running other institutions as enumerated in Table 1. A little less emphasis on cost is desirable, so that more consideration can be given to questions such as: means by which some privacy is available in lavatories, enjoyment by elderly people of their bathing time rather than army-type bath/shower parades, hand rails on paths in the grounds of hospitals, short periods of exercise for patients who move infrequently, provision of furniture with space for storing personal belongings, originality in stimulating the desire to participate in occupational therapy, whether locked doors are really necessary and the desirability to avoid the use of prison-associated terms such as "parole," and so on.

A more difficult problem than those mentioned so far is the basis for deciding who should go to such hospitals. Decisions at present seem to be based on: (a) availability of beds; (b) chronicity of illness; (c) origin of patient in nearby geographical area. The number of beds available is determined by death of existing patients and construction of new buildings. Whether a particular mental illness should be labelled chronic is usually the result of past unsuccessful treatment, but psychiatry and psychology are renowned (or notorious) for new therapeutic interventions. And given the location of the hospitals, the likelihood of family or friends in the vicinity is extremely meager. The criteria which seem to be used at present for admitting patients to these hospitals lead to the general issue of the future of such institutions. It is difficult, perhaps impossible, to suggest acceptable solutions. One observation

during my visits may highlight some of the problems involved. Not once did I notice an elderly patient talking to another patient during the hours that I spent at Claresholm or Rosehaven.

VI OTHER INSTITUTIONS ADMINISTERED BY MENTAL HEALTH DIVISION

The Alberta Hospital, Raymond, has about 50 patients, all elderly females. The Director of the Mental Health Division acts as Medical Superintendent and the hospital is administered by a matron. Although I did not have the opportunity to visit this hospital, comments made earlier about Claresholm and Rosehaven are probably equally relevant to Raymond.

Institutions for mental defectives have relatively few elderly patients and therefore do not present any special geriatric issues. Some confusion often results through amalgamating mental deficiency and mental illness statistics, and it would be helpful if in future these were separated.

VII PSYCHIATRIC WARDS OF GENERAL HOSPITALS

Responsibility for these wards, which in 1965 had a total of 138 beds, is in the hands of Hospital Boards and, indirectly, of the Hospitals Division of the Ministry. The number of elderly patients treated in such wards in Alberta is not known. The medical profession as a whole tends to favor a greater reliance in the future on this type of facility in preference to mental hospitals (5). Although some vested interests may influence this viewpoint, there are many good reasons for the recommendation. Perhaps the most important is the involvement of local communities in their own hospitals. One of the great dangers of the large, distant and isolated mental hospital is the tendency of physicians to lose their feeling of responsibility for individual patients moved there.

The costs involved (see Table 1), as well as the official function of these wards, make it impossible to consider using such facilities for the permanent care of many elderly patients. It is important therefore to establish whether elderly patients respond to the treatment offered. The answer to this question seems to depend on whether a psychiatrist attached to the relevant ward has concentrated on geriatrics. Unfortunately, few psychiatrists have specialized in this aspect of their discipline. But

when such rare individuals are available, the number of elderly patients who show considerable improvement in these wards is far greater than many physicians, and for that matter many psychiatrists, suspect. In discussing the matter with experts, it is impossible to escape the impression that there is occasionally an unnecessary tendency to give up hope and to have recourse to certification too readily. Short periods of confusion, followed by a return to adequate contact with reality may be the rule rather than the exception for the elderly, given adequate medication. Much more is now being attempted in this sphere, especially in the wards at the Foothills Hospital, Calgary, and the University of Alberta Hospital, Edmonton.

VIII AUXILIARY HOSPITALS AND NURSING HOMES

These two types of institutions are ultimately answerable to the Hospitals Division of the Ministry of Public Health, since their primary concern is with physical ailments. Hospital Boards have acted as the immediate supervising authority of auxiliary hospitals, whereas nursing homes have been built by private enterprise or religious foundations and are directly subsidized by the Provincial Government. Recent statements by government spokesmen suggest a change in policy, with future nursing homes administered in the same fashion as auxiliary hospitals. From many points of view the failure of this experiment in cooperation between government and private enterprise is regrettable. Competition between nursing homes to give the best possible services to patients was a worthy aim. Unfortunately, the benefits of capitalist competition seem only to occur when potential supply is greatly in excess of demand. With long waiting lists for vacancies and minimal government inspection, some nursing homes have not developed the desired standards. On the other hand, the best nursing homes and the auxiliary hospitals operated by religious foundations are often said to provide far more personal and humane attention to patients, than the general run of auxiliary hospitals. The timing of the final meal early in the evening and the "open door" policy for lavatories are examples of lack of consideration in some of the latter institutions.

The differentiation between patients for whom nursing home care

suffices and those where the facilities of an auxiliary hospital are required cannot always be reliably made. An even more difficult decision is the degree of mental confusion which justifies removal to a psychiatric type of institution. At the other extreme, some patients in nursing homes might be placed in senior citizens lodges, if more of these residences were available. A valuable recent survey by Dr. Crosbie and his colleagues (8) came to the conclusion that less than 10% of nursing home patients might be considered "misplaced." The report also stated that approximately 5% out of the 10% in this group of patients were sufficiently confused or uncooperative to present serious problems, but not so ill so as to require transfer to a mental hospital. In auxiliary hospitals some 35% of patients are said to suffer from diseases of the nervous system or neurosis, but none from psychosis (4). It seems, therefore, that there is a need for some specialization among the nursing homes in large cities, and perhaps also among or within auxiliary hospital services. Many advantages would accrue if a few nursing homes tended to concentrate on patients with minor mental disorders. The staff of such nursing homes might develop new skills through experience, become known for their tolerance of the aberrant patient and develop useful links with psychiatrists. Were this plan put into operation, financial support for the specialized nursing home would have to be negotiated on an individual basis. Fresh consideration might also be given to the question of building larger nursing homes. These allow a greater degree of potential specialization with difficulty of egress in some wards.

A recent innovation in Calgary has been an arrangement whereby nursing homes and auxiliary hospitals can consult with a psychiatrist who has specialized in geriatrics. A peripatetic nurse who has received a short training course is also available to the institutions. This type of liaison is clearly a large step in the right direction. The knowledge that outside medical help is at hand has indirect results in strengthening the self-confidence of staff, quite apart from the learning situations which the arrangement provides.

The increase in the number of older people in the population shows no sign of diminishing and waiting lists for nursing homes, as well as auxiliary hospitals, demonstrate the need for more of these facilities. Those who are waiting often occupy more costly beds in general hospitals.

As the size of the operation grows, there is a danger that too much power is concentrated in the hands of one administrator - however benevolent a dictator he may be. A greater adherence to rigid rules and a possible neglect of the welfare of some individual patients may also ensue. The length of time which a bed may remain unoccupied while a patient is removed to an active treatment institution, and even the decision to remove him, can easily become matters which the individual patient or his family cannot influence. Many precedents exist elsewhere where the size of an organization is correlated with neglect of the individual. When an individual's whole life is circumscribed by the few feet surrounding his bed, it is necessary to be constantly alert to the possible grave harm to mental health through unthinking acts by those who possess the best of intentions. Notwithstanding these criticisms and warnings, it is proper to echo the Prime Minister of Canada's praise of the Government of Alberta and its Ministry of Public Health for the imaginative way in which they have established auxiliary hospital and nursing services.

IX SERVICES IN PRIVATE HOMES

Various ways of providing for the needs of the elderly in their own homes have been discussed in a separate brief (1) and the case for greater emphasis on these types of services is made there. Welfare agencies and departments of all levels of government provide for facilities of this nature, but in limited amounts. Meals on Wheels, Home Makers/Help Services, pensions, financial assistance, public health nursing, are examples. The Victorian Order of Nurses is singled out for special comment because the Calgary branch is facing an economic crisis. This service is financed in large part by the United Fund. It now seems as if it will have to curtail its activities rather than expand them in accordance with increasing demands. The Provincial Government makes a small grant of approximately $15,000 to the provincial headquarters of VON, but this seems unduly parsimonious. In the welfare fields the Provincial Government underwrites 80% of costs of comparable activities under Preventive Social Service legislation. Home nursing of the type under consideration should be viewed as a major preventive facility and subsidized to a much greater extent than heretofor. It seems a terrible

waste for senior VON personnel to have to spend their time soliciting for funds, instead of fulfilling their supervisory nursing roles and increasing contacts with physicians in general and psychiatrists in particular.

X HOMES FOR SENIOR CITIZENS

A recommendation to provide housing subsidies for needy older people is made in the Alberta Council on Aging Brief (1). The necessity for an expansion of existing programs for lodges and units is demonstrated by a waiting list of some 750 people in Edmonton and 290 in Calgary. (These figures should not be considered completely reliable since some of those who need accommodation do not request it, because they feel it is hopeless to do so, while some others probably pass away while on a waiting list of this size.) Existing figures suggest that some rural areas may be oversupplied with this type of accommodation. The five lodges in the Province where residents number less than 40 (out of a possible 50) are Sedgewick, Bow Island, Raymond, Claresholm and High Prairie (15).

Improving future lodges through adding more single rooms, and providing some kind of stimulating recreational facilities in existing lodges raises the question of the finances and administration of this program. Table 1 showed the success that has been achieved in organizing these homes on a ridiculously low budget. A more liberal attitude towards expenditure with the support of local taxes would permit the appointment of qualified consultant staff as a resource for matrons. Such specialists are needed if the homes are to develop imaginative facilities and become more lively than they are at present. Special consideration should also be paid to geographic locations of future homes, and public transport facilities, in particular on Sundays, available to existing homes. Geronters (16) enjoy visiting; reducing contact with families and friends, who themselves are often elderly, because transport is unavailable has detrimental effects on mental health.

XI POVERTY

Somerset Maugham summarized the problem of economic needs and their effects by saying "money is the sixth sense without which you cannot make the most of the other five." The relation between mental health and

financial hardship would be difficult to document, but it can be taken as a given that poverty can prevent individuals from participating in activities and buying facilities necessary to maintain mental health. The relation between age and poverty is well established. Sixty percent of low income individuals were 55 or older in 1961 and nearly a third were over 70 (13. p. 121). In Alberta there are 91,590 people in receipt of old age security and approximately 50% of these receive guaranteed income supplements (15). The Provincial Government helps nearly 18,000 elderly people through its various public assistance programs, including many residents of nursing homes and auxiliary hospitals.

These figures point towards the fact that a large number of the elderly are not participating in the improved standards of living of other Albertans. There are probably over 60,000 old people who are attempting to subsist on a little over $100 a month. Facilities for the elderly, supported out of public funds should cease being considered as a welfare handout requiring increased taxation, but as a right. In a very important sense it is a privilege to contribute to the well being of the older Albertans.

XII INSTITUTIONALIZATION AND GENERAL ASPECTS OF AGING

Learned journals have recently paid considerable attention to the dangers of institutionalization and have even identified a group of symptoms as the "institutionalization syndrome." An important aspect of this problem seems to be that adherence to rules in the institutional setting becomes an end on its own for resident and staff alike. Patients easily develop a fear of any change in routines and show a passive recipient attitude. This tendencyis probably accentuated in the elderly, since, with age, there is in any case a greater reliance on habitual forms of behavior. For this very reason, elderly patients or residents in homes need to be stimulated by a certain amount of change. Some disengagement from youthful activities may be desirable, but complete disengagement constitutes preparation for death and not active living.

Research findings about institutionalization have many implications for mental health. The most obvious is that means of avoiding this form of care should be considered a major aim of public programs and projects.

No less obvious is the desirability of attempting to de-institutionalize the institutions that have to exist. Even if it takes longer and causes more bother for a patient to do things for himself or for herself, staff should resist their tendency to "save the patient trouble." There is much truth in the saying that kindness kills.

Drastic changes can also cause harm and even the expectation of change has been shown to result in acute stress in the elderly (14). Habits and rules are the necessary supportive background for coping with change. The best balance between amount of desirable change and reliance on habitual behavior will vary. As usual, the enemy of smooth running of organizations is individual differences, but staff should be trained to welcome this enemy and react appropriately. The institutionalization of staff is perhaps as great a danger as the institutionalization of patients. Actions which involve risks of something going wrong are often to be preferred to apparent gilt-edged security. Further, the tolerance of the patients for slight degrees of change provides a type of knowledge of results of the efforts of the staff. One reason for the unpopularity of nursing the elderly sick is the absence of signs of improvement. Any kind of measure of change counteracts this and hospital records of such changes have a reinforcing function. Even a reduction of soiling the bed from every night to once a week, or perhaps six times a week, is a worthy aim and results should be noted. Change or labor turn-over of staff is relevant in this context. Although need for some permanence in staffing arrangements is desirable, staff and patients alike will benefit from the infusion of new personnel who can be expected to introduce different viewpoints and attitudes.

The institutionalization of staff can also be considered as equivalent to a tendency to stereotyping. When we refer to "the aged," "the elderly" or "them" we are indulging in a form of prejudice, to which older people understandably object. Many of the elderly dislike mixing with people of their own age group, possibly because they do not want to be labelled as "another oldster." The tendency to stereotype comes to the fore in the attitude of some staff towards complaints. Older people complain more, it is said, and therefore the problems they raise can be ignored. There is little evidence that the aged in fact do voice complaints more often than the young, but it is certainly untrue that when

they complain there is necessarily nothing to complain about. A similar type of fallacy occurs among more sophisticated professionals in discussions of depression. There is good evidence to show that the incidence of depression is greater among the aged, but this does not imply that a measure of average depression level is higher in the normal aged. More older people may suffer from depressions, although those who do not may be less depressed than "normal." Geronting (16), as it has been termed elsewhere, should be the expected way of life.

Some of the conclusions to be drawn from this cursory discussion are: (a) the requirement of a greater emphasis on record keeping; (b) the desirability of short training courses for staff working with the aged at any level; (c) the need for more staff so that time is available for stimulating individual patients.

XIII DECISION MAKING PROCESSES AND SOME ADMINISTRATIVE PROBLEMS

Western democracies have espoused two opposing views on the most efficient methods of controlling government expenditure. On the one hand, there are those who want decision making, and its justification to be as public as possible. On the other hand, there are many who wish to allow senior civil servants or the minister to be complete masters in their own homes, with dismissal as the threatened sanction against incompetence. Open discussions tend to be favored in the United States, private decisions with only occasional parliamentary questioning has been the traditional British way. The compromise solution, which attempts to obtain the benefits of both methods, has been the formation of representative advisory committees consisting of members not mainly representative of the vested interests involved. The Government of Alberta has established a number of councils of this nature, the Universities Commission being a recent example. Their functions vary, while their relationships with the executive and legislative branches of government cover the range from almost complete autonomy to almost complete dependence. In the mental health field there is already a Board of Visitors, but its powers and the pressures it can exert seem minimal. An advisory council, with both lay and professional representation, to plan future developments in the mental health field seems a desirable aim.

The drawbacks of having too much power in the hands of one or two individuals are well known. It has been rightly said that "power corrupts and absolute power corrupts absolutely." It should also be recognized that the Minister himself, as well as his senior civil servants, is under pressure to economize. As a result, he probably does not have the number of senior staff needed to allow him, or the public servants involved, the time required for sufficient consideration of the multitude of issues involved in the mental health field. An advisory council might be of help in justifying an increase in senior staff in the Ministry itself. Although membership of the Council would not be anything like a fulltime occupation, the people concerned could be expected to develop a depth of knowledge necessary to add weight to their recommendations. The annual parliamentary debate on all health estimates, especially in a legislature with a large majority government, does not encourage individual members to acquire the knowledge needed to have an overview of the total Alberta mental health situation, or to criticize details. This would not be true of an advisory council.

XIV CONCLUSIONS AND MAJOR SUGGESTIONS

Numerous recommendations are scattered throughout this report, and these are summarized on the final page. They are not repeated in this present section which is confined to a few major issues.

(a) Organization. Having given some thought to Alberta mental health problems, I have come to realize that most of the more obvious solutions have important drawbacks. A proposal to close down a mental hospital implies that millions of dollars of public money must be considered as wasted. This kind of recommendation is not to be made lightly. The Mental Health Study will be in a far better position to weigh pros and cons, but even it is limited by time pressures. What is required therefore is a permanent mental health study group. Admittedly the terms of reference of such a group will raise all kinds of difficulties, but these are not insurmountable, provided that the Minister and his staff view the proposal with favor. Should the suggestion be unacceptable, the Human Resources Development Council might consider the establishment of some alternative body with the same type of function.

Problems of administration at local levels have received insufficient

emphasis in this report and deserve more consideration. The kind of independent advisory board which has been suggested, might well decide this to be the first area to which it should give attention. And the Minister might welcome such a decision.

(b) Staffing. In my opinion, there can be no question that a reconsideration of staffing needs warrants receiving the label "first priority." The assessment of needs should be linked with a plan to meet them. Such a plan would undoubtedly include the provision of special emoluments to attract professional staff to outlying districts and the appointment of consultants in various specialties to advise staff and train helpers.

It is important to avoid the kind of over-professionalization which excludes potential workers from the areas under discussion, because they lack long years of university education. There is good evidence that a large untapped supply of people with the necessary personal qualities exists. They could make invaluable contributions after attending short training courses, culminating perhaps in some form of certification. Government sponsored courses should be offered not only at universities, but also at less populated centers in a variety of aspects of psychiatry, gerontology, sociology, etc. Such courses should be open to those working or intending to work in mental hospitals, as well as those employed in nursing homes, auxiliary hospitals and senior citizen lodges. These courses would be expected to upgrade the level of services offered in a short period of time.

The appointment of a suitable psychiatrist to spend at least two days a week both at Claresholm and Rosehaven might have far-reaching effects on some of the patients in these institutions. A special allowance of something like $200 a month to attract adequately trained nurses to these hospitals would be a negligible expenditure in comparison to potential benefits. The appointment of a consultant occupational therapist to stimulate and train aides in the various institutions is clearly desirable.

A special effort should be made to subsidize a few psychiatrists in different parts of the Province to take advanced training in geriatrics. The presence of such experts is likely to be of the greatest benefit to other physicians and professionals working with older people. The appointment of consultant occupational therapists to advise nursing homes and

auxiliary hospitals throughout the Province is also recommended. Similar types of appointments of social workers, recreational experts or psychologists are suggested for Senior Citizens Homes and the Golden Age Clubs.

The backbone of most of the services discussed in this report are nurses and nursing aides. A careful survey of future nursing requirements would surely suggest that there is an urgent need for increasing the number of nurses in training at all levels. The problem has to be faced, however, that many nurses prefer not to work with geriatric patients. This itself requires investigation, with the aim of suggesting ways by which such duties can become more desirable.

(c) Research. The present report has placed the major emphasis on services. This is at variance to recent apparent trends of society in general, and universities in particular, which upgrade research to the detriment of other activities. At its best, research does not divorce itself from practice. The halo effect of research can usefully spread itself to stimulate interest in newly established professions and disciplines. A priming of research pumps in the fields of psychiatry and psychology is likely to increase the supply of personnel with knowledge of, and interest in, working with older people. The research workers themselves are necessary for the provision of educational courses suggested earlier. The Alberta Council on Aging has made specific recommendations for a Center of Gerontology in one of the Provincial universities (1). This type of Institute should not be thought of as diminishing the monies available for services or programs, but a necessary adjunct to them.

(d) Voluntary Work. Governments cannot provide for all the needs of the elderly sick and they should, in any case, be the object of loving care. Visiting of patients in Claresholm and Rosehaven could be a project undertaken not only by established service clubs in other parts of the Province, but also of university students. The new University at Lethbridge might consider the possibility of "adopting" the Alberta Hospital, Claresholm. What is required is not an invasion by hundreds of boisterous students, but one or two individuals committing themselves to some general responsibility for one patient. Inexpensive jewellery, reasonable clothes, books and Christmas presents would all be welcome. It is however, the visiting itself which, in the long run, might prove most valuable, but would entail real sacrifices.

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SUMMARY OF RECOMMENDATIONS

1. Consultation by Mental Health Staff regarding statistical information (p. 2).

2. Improvement of transport facilities to mental hospitals (p. 13).

3. Privacy in lavatories, bathing arrangements, hand-rails, exercise, furniture, occupational therapy, security arrangements at Claresholm and Rosehaven (p. 15).

4. Criteria for assigning patients to Claresholm and Rosehaven (p. 15).

5. Separation of mental health and mental deficiency statistics (p. 16).

6. Timing of evening meal and privacy in lavatories in auxiliary hospitals (p. 17).

7. Specialization by nursing homes for different ailments and consideration of ideal bed capacity (p. 18).

8. Psychiatric consultants for nursing homes and auxiliary hospitals (p. 18).

9. Increase in number of auxiliary hospitals and nursing homes (p. 18).

10. Financial support for Victorian Order of Nurses (p. 19).

11. Increase in number of lodges and units of senior citizen homes, more single rooms in future lodges, appointment of consultants and public transport facilities in existing lodges (p. 20).

12. Emphasis on record keeping, training courses and more liberal provision of staff in all institutions (p. 22).

13. An Advisory Council for mental health (pp. 23 & 24).

14. Government sponsored short training courses (p. 25).

15. Appointments at Rosehaven and Claresholm, special emoluments for staff in outlying districts, appointment of consultants for groups of institutions, advanced training for ~~psychologists~~ psychiatrists (p. 25).

16. Increasing numbers in nursing training institutes and investigation into means of making geriatric nursing attractive (p. 26).

17. Funds for research and a gerontological center (p. 26).

18. Voluntary work and visiting (p. 26).

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